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The Family Physician's Role in a Continuum of Care Framework for Newfoundland and Labrador

A Framework for Primary Care Renewal

Report of the Primary Care Advisory Committee
Kathy LeGrow, Chair

Presented to the
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GLOSSARY OF TERMS

ARNNL	Association of Registered Nurses of Newfoundland and Labrador
Accountability	Reliability based upon the ability to demonstrate and take responsibility for performance, in light of agreed upon expectations[1]
Continuum of Care	consistent care provided from the earliest contact incorporating prevention, treatment and rehabilitation from a variety of health care providers, over a continuum of time, in a variety of settings, on a 24-hour a day, 7-day a week basis
Critical Mass	the minimum number of individuals that must exist in a particular population to support proposed health care structures
CNS	Center for Nursing Studies
DOHCS	Department of Health and Community Services
Evidence-based decision making	Decision making based on unbiased analysis of reliable, valid data
FP/GP	family physician or general practice physician
F/P/T	Federal/Provincial/Territorial
Interdisciplinary Model	approach to primary health care delivery which emphasizes universally accessible continuous, comprehensive, coordinated primary health care provision for a defined population through the shared responsibility and accountability of physicians and all other primary health care providers[2]
NLMA	Newfoundland and Labrador Medical Association
MCP	Medical Care Plan of Newfoundland and Labrador

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[1] – Attorney General of Canada definition

[2] – adapted from the Working Group on Interdisciplinary Primary Care Models, Advisory Committee of Interprofessional Practitioners (AGIP). Interdisciplinary Primary Care Models: Final Report April, 1997

Patient/Client	when an individual enters the health care system, he/she is referred to as a patient or client, depending on the health care provider seen (e.g. physicians typically see patients, while social workers see clients)
Population	a body of individuals who have a quality or characteristic in common (for example, a population of diabetics, the population of Burgeo, or a population of physicians)
Population-based approach	an approach to health care service delivery that considers the health needs of a specific population
Primary care	the first level of contact with medical care, provided primarily by physicians (including office visits, emergency room visits and house calls) Primary care operates inside the larger context of primary health care
Primary health Care	the first level of contact of individuals, the family, and the community with the health care system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process[3]
Regional Health Authority/board	the regional body that administers institutional and community healthcare programs and services in a particular geographic region. Currently there are fourteen regional boards in Newfoundland and Labrador, eight institutional boards, four community services boards, and two integrated boards that deliver both institutional and community services
Secondary care	health care received beyond the first level of contact with the health care system, primarily provided by specialist physicians
Tertiary care	specialty medical care provided by a specialist or subspecialist at an accredited facility

[3] – World Health Organization

Introduction

The Primary Care Advisory Committee

The Primary Care Advisory Committee (PCAC) first met on September 7th, 2001 to address issues surrounding the involvement of primary care physicians in primary health care renewal initiatives. Minister Julie Bettney appointed Chair Kathy LeGrow and ex-officio member Dr. Ed Hunt, as well as the fourteen-member committee, to respond to issues raised at the June 18th meeting called by the medical directors and physicians from each of the regional health boards.

Regional medical directors expressed concerns about the current crisis in primary care delivery, recruitment and retention of physicians, service gaps and pending service withdrawals. The Primary Care Advisory Committee was developed to address physician concerns in a transparent way. Discussions occurred in an open forum, stakeholders were broadly represented, and free dialogue was encouraged. The work of the PCAC was timed to coincide with the seven Provincial Health Forums held throughout the fall of 2001, concluding with the Provincial Round Table held in Gander on November 27th and 28th, 2001.

The group of fourteen was chosen to reflect diverse perspectives in primary medical care[1]. Comprised mostly of physicians (ten in total), the physician complement represented rural and urban, salaried and fee-for-service doctors. As well, the physician group represented the perspectives of medical directors, the Newfoundland and Labrador Medical Association (NLMA), Memorial University's medical school, the Twillingate Primary Health Care Enhancement project, public health, the CSAT program, recent and not-so-recent graduates. To balance the perspective, a registered nurse (appointed by the Association of Registered Nurses of Newfoundland and Labrador (ARNN), a nurse practitioner (appointed by the Center for Nursing Studies (CNS)), a public policy expert, and a consumer representative were also appointed to the committee.

In September, 2001, the committee proposed and ratified the terms of reference that outline its mandate, listed below:

Terms of Reference:

1. To advise the Department of Health and Community Services on physician issues related to Primary Care Reform, taking into account the impact Primary Care Reform will have on the delivery of physician services to the public.

2. To engage in discussion with stakeholders on all elements regarding the development of primary care reform in Newfoundland and Labrador so as to be consistent and compatible with the goals and the framework set forth by the

[1] – Appendix A: Primary Care Advisory Committee Membership

National Committee on Primary Health Care Reform, endorsed by the Federal/Provincial/Territorial (F/P/T) Ministers of Health. The F/P/T framework includes:

(i) Primary health care organizations with contractual obligations for the planned provision of a defined set of comprehensive services to a defined population.

(ii) Interdisciplinary teams with enhanced roles for registered nurses, pharmacists, and other health care providers.

(iii) An emphasis on population based approach to care, quality improvement, and the measure of health outcomes.

(iv) Linkages to pharmacies, other community services and secondary and tertiary systems.

(v) Enhanced use of health information systems.

(vi) Funding arrangements to promote quality, accountability, and efficiency.

3. To make recommendations to the Minister of Health and Community Services on a framework for "primary care" which facilitates the effective and timely implementation of "primary health care" reform in the province.

4. The framework for "primary care" should address the key issues for physicians: compensation arrangements, contractual arrangements with regional health boards, clinical autonomy and independence, integration with "primary health care" teams, service expectations (e.g., on call; hospital-based services, preceptoring) and accountability.

5. To propose a plan of action which overcomes barriers to change and which complements broader "primary health care reform".

6. To respond to media and public interest in the work of the committee.

7. To appoint working groups to examine specific issues as needed.

8. To submit a final report to be presented at the Minister's Forum on November 28, 2001.

9. To monitor and evaluate progress on the recommended changes following completion of the Minister's Forum.

Process

In light of term of reference number four, the group agreed that the key issues to address were: mode of compensation, contractual arrangements, and service expectations. Three working groups[2] were formed within the committee to discuss these issues. Nine additional members were invited to assist the committee via the working groups, these included: two consumer representatives, one representative of the Newfoundland Pharmaceutical Association (NPA), one representative from the CNS, one representative of allied health professionals, one representative of Treasury Board, one physician representative from the MCP program, one representative of a regional institutional board, and one member representing the legal profession. Five departmental ex-officio members were added to round out the committee and provide technical support. These five, along with the chair of the committee, formed the steering committee that guided the process. The total membership of the PCAC, including working group and ex-officio members, came to twenty-nine with a physician complement of twelve[1].

The representative from the NPA respectfully declined the invitation to participate in committee activity citing prior work commitments. In October 2001, the NLMA announced job action that involved physician withdrawal from government committees. The result of this job action was the non-participation of three physicians out of the twelve represented on the PCAC. In late October, one consumer representative resigned from the committee. As a result, the current committee and working group membership consists of twenty-four active members in total, with a fully participating physician complement of nine.

It is important to note that the three fee-for-service physicians and the consumer representative were present for the ratification of the terms of reference and guiding principles, thus their input and values did have an impact on the future decision making processes of the committee. The remaining physicians on the committee were challenged with the task of representing the issues of the three that had withdrawn.

The PCAC has met six times since its inception, working towards consensus on the issues surrounding primary care reform and recommendations to address these issues. Initial full committee and individual working group meetings focused on broad discussion of many concerns. A series of open-ended questions, prompted by this first round of discussions, were developed by the steering committee and considered by the working groups. During this period, committee members gathered information form a variety of sources including presentations given at committee meetings[4] as well as numerous research papers and reports. The steering committee then identified the most pressing issues brought forth in these early meetings and presented them to the committee for discussion. Once

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[2] – Appendix C: PCAC Working Groups

[3] - Appendix B: PCAC Working Group & Steering Committee Membership

[4] – Appendix D: Presentations to the PCAC

consensus was reached on the issues, the committee set forth to develop recommendations to address them.

The recommendations in this report were developed at a weekend meeting in early November 2001. This process involved dividing the committee into two groups on day one for separate discussions, using a question-and-answer grid developed by the steering committee to sum up the issues and elicit recommendations. Each group was challenged to answer four separate questions on two sets of issues. Independent facilitators were called in to assist with this process. The next day the groups reconvened and collectively reviewed their findings. From this discussion the recommendations were developed. The recommendations are intended to define the physician's role in a **Continuum of Care** framework.

This report reflects the full consensus of the committee as well as the working group members on those recommendations. Given the short frame in which this committee has worked together, *we do not propose to have all the answers on primary care renewal.* This report is not intended to provide a specific blueprint for change, nor an exhaustive review of the current research on primary care innovations. However, it is unique that its' contributors wore many "hats" and all were encouraged to speak freely in a supportive forum. Through our unedited and often heated discussions, we have put our differences aside and succeeded in meeting the mandate given. We have achieved consensus on the issues at hand and on the recommendations that we feel will address these issues. This process has demonstrated that *broad stakeholder discussion and commitment to change can work and has merit.*

Background: Why do we need Primary Health Care Renewal?

Medicare: Past and Present

When Tommy Douglas introduced his vision of Medicare to the Saskatchewan legislature in 1961, his plan was twofold. First, his goal was "to remove the financial barrier between those who need health care and those who provide it"[5] This vision has become a reality, and all Canadians regardless of economic status may avail of physician and hospital services at no cost to themselves or their families. Medicare, while not perfect, still stands as a blueprint for other countries on how to provide socialized medicine. The second step outlined by Douglas was to establish a new type of delivery system in the health care field, one that included preventative medicine, community-based care, and alternate mechanisms for payment of health care providers. Forty years later, this vision of Medicare has yet to be successfully implemented on a national basis. The end result of this implementation failure has gradually become evident throughout Canada: population health needs have changed, but the system has failed to change with them. The sustainability of our health care system has come into question, and policy makers are

[5] - Tommy Douglas Research Institute. *"Revitalizing Medicare: Shared Problems, Public Solutions".* January 2001. P. i Tommy Douglas Research Institute.

scrambling to "skate in the direction the puck is going"[6] to keep up with changing demands on the health care system and skyrocketing health care costs.

It has become clear that in order to maintain a healthcare system that is comprehensive, universal, accessible, portable and publicly administered, as legislated by the Canada Health Act, renewal of the health care system is imminently required. Before we can make changes to the system, however, it is important to recognize how we got to where we are today, and what challenges lie ahead.

Health and Illness in the 20th century

During the first half of the 20th century, health was viewed as the absence of illness. Episodic illnesses such as tuberculosis tended to make up much of a physician's time, and take up most beds in hospitals. In 1901, a woman born in Canada could expect to live, on average, until the age of 50, and a man until the age of 47. Almost a century later, the situation has changed greatly. Since 1948, the World Health Organization has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Access to medical care, improved sanitation and diet, and advances in medical technologies have all played a role in reducing infectious diseases, effectively enhancing and prolonging the lives of Canadians. The life expectancy for females today is 81, for males 75. All of these changes have resulted in very different demands being placed on the healthcare system than those present at the introduction of Medicare, forty years ago [7,8].

With an aging population, more chronic illnesses are seen in physicians' offices and hospitals today. These illnesses require a different approach to treatment than the infectious diseases of yesteryear. Health promotion, health education and illness prevention play a much larger role in health service delivery than ever before. For example, preventative care such as support for cessation of cigarette smoking and promotion of increased daily physical activity are two important measures that could greatly decrease chronic illnesses seen in patients who are advancing in years.

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[6] - Dr. Paul Bonisteel, President, CFPC Newfoundland Chapter
[7] – World Health Organization Website
[8] - Statistics Canada Website

Advances in information technology, medical technologies and alternative therapies require physicians to constantly stay abreast of trends in health care, to properly educate patients who have more access to information and more autonomy than ever before in deciding on their own care. Long-term care facilities and home care provisions are required to accommodate the needs of an aging population. Other providers of health care, such as nurse practitioners, physiotherapists and health educators to name a few, all have a role to play in ensuring that "a state of complete physical, mental and social well-being" is achieved by the population today and in the future.

The goal of primary health care is to ensure that the above challenges are met. Central to this goal is the incorporation of interdisciplinary teams of health care providers to provide a continuous, coordinated, comprehensive set of services accessible to all individuals in a defined population. A major objective of primary health care renewal is enabling the patient/client to be the champion of his or her own care.

II/ Primary Health Care Renewal and Primary Care Renewal Initiatives

An Important Distinction

The World Health Organization defines Primary Health Care as "the first level of contact of individuals, the family and the community with the national health care system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process". Primary Health Care addresses the main health concerns in a community, providing promotive, preventative, curative, supportive and rehabilitative services accordingly. It is designed to focus on meeting population health needs[9].

One of the key components of primary health care enhancement is the collaboration of all health care providers to enable a team approach to care. This should benefit patients, as they will have better access to streamlined, comprehensive care. The team approach implies a sharing of work where clinical skills are appropriate, thus reducing the workload of physicians. This could allow family physicians more time to focus on complex cases, partake in professional development, and perform hospital services. Nurse practitioners are an untapped, but highly valuable resource, to family physicians. They can provide a variety of skills that family physicians currently provide. The incorporation of nurse practitioners into family physician practice is a prominent feature of most primary health care enhancement initiatives.

Primary care is defined as the first level of contact with *medical* care, that which is provided by a physician, be it via an emergency room visit, office appointment or house call. The terms "primary medical care" and "primary care" are interchangeable in the health care field. Primary health care is the larger context inside which primary medical

[9] - World Health Organization Website

care operates. The committee has been asked to focus on recommendations for primary care renewal and how these can work within larger primary health care renewal initiatives. While we refer to primary health care renewal repeatedly in this document, the focus of the committee's recommendations is to specifically address issues involving primary medical care.

What has been happening thus far in Canada? In Newfoundland and Labrador?

Renewal of primary health care is not a new topic nationally. In the 1970's, Quebec established a series of Community Health Centres, known as "Centres Locaux de Services Comunautaires" or CLSCs. Ontario followed suit shortly thereafter, opening community-governed, funded community health centres (CHCs) designed to improve access for hard-to-serve populations. Neither project, however, took the place of the standard mode of primary care, which was the solo physician practicing independent of other providers. In the 1990's, a series of pilot projects were undertaken across the country to test primary health care reforms. The Federal Government announced the establishment of the Health Transition Fund in 1996, allocating 200 million dollars over a four-year period to aid the provinces with the establishment of innovative primary health care reform projects. This fund stimulated the implementation of three projects in Newfoundland and Labrador[10].

The Primary Health Care Enhancement Project (PHCEP) was established in Newfoundland and Labrador in 1997, with $3.5 million allocated over 3 years to set up test sites for locally developed innovations in primary health care service delivery and the continuing education of health care professionals in rural areas. Twillingate, Port Aux Basques and Happy Valley-Goose Bay were chosen as the test sites. Teaching Units were set up at each site and the first graduates of the nurse practitioner program at the Centre for Nursing Studies were assigned to each site. Specific goals of service, education and evaluation and research were set for each site to develop a primary health care approach relevant to each area.

While such initiatives have aided in the fine-tuning of primary health care renewal in these locations, none of the above projects was intended to alter the provincial primary health care system *in toto*. This is due in part to the tangential nature of pilot projects, and their inherent inability to crossover to mainstream systems. However, larger scale projects in Canada have met with little success in manifesting changes to primary health care delivery due for the most part to barriers to system-wide change. In order to understand these barriers, we need to take a look at current physician practice and how it has been established in Canada.

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[10] - Hutchinson, Brian. *So Much Innovation, So Little Change*. Health Affairs, 20, no.3 (May/June 2001): p.122.

III/ Barriers to Change

The Current Situation: Physicians

One of the themes that have emerged from earlier pilot projects is that the goals of primary health care renewal are best met with the endorsement of physicians. But the majority of physicians in Newfoundland and Labrador are not encouraged to participate in primary health care renewal initiatives because of barriers to change inherent to our current system of health care delivery. Three barriers to change identified by the PCAC are physician remuneration, physician lifestyle, and system disconnection.

A shortage of physicians in Canada over the last decade has exacerbated these barriers. In the early 1990's, medical students in Canada had a choice of program: a 1-year rotating internship or a 2-year family practice residency. Typically, 50% of students would choose the family practice residency, with the other 50% choosing a rotating internship. After completing their 1-year rotating internship, graduates had the option of going into general practice, entering further training in a specialty, or doing locums. On average, one half of these graduates chose to go into general practice, such that 75% of all graduating physicians were working as GP/FPs. In 1993, however, the Federation of Medical Licensing Authorities of Canada changed the licensing legislation such that only those doing a 2-year family practice program were permitted to enter general practice. However, medical schools in Canada did not increase the number of positions for family practice residents correspondingly. Thus, Canada's health care system has been operating at a net loss of family physicians since 1993. This is significant concern that should be addressed at the national level.

Physicians exiting the health care system in Canada are not being replaced by a requisite number of new graduates. This fact has significant impact for the health care system in Newfoundland and Labrador. Recent supply data produced by the Department of Health and Community Services indicates that while the number of specialists in the province continues to increase, in recent years there has been a loss of family physicians. With a substantial number of physicians reaching retirement age, recruitment and retention of new physician graduates will require that government and individual communities find innovative ways to address the barriers below to make this province an attractive location in which to practice medicine.

Remuneration

Seventy percent of physicians in this province are paid via the fee-for-service fee schedule that pays for each patient service individually, based on the complexity and time taken to provide that service. Since this method of remuneration was established at the

same time that Medicare was first introduced to Canadians, in most instances it has been the only option available to most physicians setting up a practice in Canada.

As discussed earlier, the needs of patients have changed since Medicare was established, but the current fee-for-service fee schedule does not provide mechanisms for changes to physician practice to accommodate changing patient needs. First of all, the fee-for-service fee schedule has built-in artificial restrictions on the efficient use of human resources. It does not reimburse physicians for incorporating other providers into their practices, in fact, it serves as a disincentive in this regard. For every patient seen by an alternate provider in a physician practice, the physician not only loses income due to the lost patient visit, but he or she must also pay the alternate provider's salary. Secondly, the fee schedule does not reimburse physicians for continuing medical education and other professional development activities. This may make it difficult for physicians to maintain clinical skills. Finally, the fee-for-service fee schedule has shifted in its focus from a service delivery mechanism (as it was intended) to a physician payment mechanism. Payments follow the physician, not the patient. As a result, the fee-for-service fee schedule is criticized as being inequitable and failing to meet population health needs.

Physician Lifestyle

Physician shortages and disincentives to incorporate other health care providers into practice results in increased workload for fee-for-service physicians. In an effort to provide optimal care to every patient accessing their service, fee-for-service physicians are suffering burnout. In response, some physicians are choosing not to provide hospital or other services, or choosing not to take on new patients.

Thirty percent of physicians in this province are salaried, particularly in rural areas, and they are suffering burnout as well. Salaried physicians receive a predetermined sum of money in exchange for an agreement to provide specific services to a defined population of patients. Service expectations usually include clinic services, inpatient care, on-call, emergency room coverage, and other hospital services. The salaried payment method encourages the incorporation of other publicly funded health care providers into physician practice. However, due to physician shortages, salaried physicians find themselves being spread too thin. As a result, they too must try to balance their responsibility to patients with their expectation of a reasonable lifestyle. In rural communities, where there may be only a handful of physicians, this can be a daunting task.

The statistics gathered by the College of Family Physicians 2001 Workforce Survey illustrate the extent to which physicians provide services beyond the 9-to-5 workday. The average duration of service that is provided by a primary care physician in this province is approximately 62 hours per week (excluding call). 80% of physicians in this

province perform on call. This adds up to 25 hours to the workweek, extending it to 87 hours[11].

In the past, physicians expected to provide all medical services required by their patient population, regardless of the time or travel involved. Patients shared this expectation of service as well. Physicians today still expect to provide a broad range of services, however, not at the expense of lifestyle goals. New family physicians coming out of medical school have decided to "practice what they preach", that is, they have decided to create for themselves the healthy, balanced lifestyle they encourage in their patients. Salaried physicians lacking support in rural communities have expressed the same concerns for their health and well being, and some have decided to move their practices to urban settings. As mentioned previously, fewer and fewer fee-for-service physicians are providing after-hours, inpatient, obstetrical or emergency room care due to lifestyle concerns. This has led to service gaps in both urban and rural settings.

System Disconnection

Gaps in service occur for other reasons as well. In the current system, particularly in urban areas, the FP/GP typically practices in isolation of other health care providers, including other physicians. According to the College of Family Physicians 2001 survey, 73.4% of physicians in Canada work mainly in solo practices, and fewer than 10% of primary care physicians work mainly in multi-disciplinary practices. Written reports from other health care providers to the FP/GP are slow to be transmitted, such that family physicians may not have accurate information to make a diagnosis at the time that a patient presents symptoms in their office. Some patients, either by choice or by circumstance, do not have a family physician of their own and as a result, become what are known as "orphan patients". These patients, who typically visit walk-in clinics or emergency rooms, receive disconnected care from a series of different health care providers. In both cases, patients' medical records are dispersed among a variety of clinics and institutions, making it difficult to provide them with consistent care. Patients who see a variety of health care providers, including physician specialists, may receive disjointed care as these individuals are typically not in close contact with family physicians.

Another source of system disconnection is an increasing lack of physician affiliation with institutional and community health boards. The current health care system has no mechanism in place to connect the FP/GP to the hospital or community health care board. This is a voluntary association. Board affiliation is a privilege that provides physicians with opportunities for continuing medical education, collegiality, networking and consultation with other physicians in return for services provided to the board. In the past, board affiliation was encouraged and valued by both health boards and physicians. Currently in Newfoundland and Labrador, approximately 40% of physicians provide

[11] - College of Family Physicians of Canada. Initial Data Release of the 2001 Nation Family Physician Workforce Survey. October 2001.

emergency room coverage and 35% provide some hospital and inpatient services. For a variety of structural and practice considerations, there has been a decline in the number of physicians providing hospital services. The majority of physicians today are choosing not to provide hospital services. This may be linked to remuneration, lifestyle, or competency concerns, all of which are rooted in the current health care system. As a result, service gaps are occurring in hospitals and communities throughout the province[12].

Summary of Barriers

Entrenched in the current system, the issues around physician remuneration, lifestyle concerns and system disconnection, exacerbated by physician shortages, all culminate to result in diminished access to a **Continuum of Care** in this province. We know from previous discussion in this report that patient needs and expectations are changing. However, the barriers to change in primary care delivery outlined above preclude changes from occurring to accommodate patient needs in the primary health care system.

As a result of these systemic barriers, it has come to the attention of the committee that patient access to appropriate health care services may be compromised in some instances. The skill sets of primary care physicians and nurse practitioners in particular are generally not being maximized, and hospitals are often incapable of maintaining acceptable levels of service delivery without great difficulty. All of these problems result in additional costs to the health care system budget to provide services. This committee has also noted that due to these barriers, relations among physicians and all primary health care providers and health administrators/governments in many instances are mistrustful and laced with frustration. Frustration arises due to the inability of the health care system to change, to better address the realities of patient care needs. Proponents of change are limited by what they can achieve in the current system.

The combination of disincentives to incorporate other providers into physician practice, system disconnection as it relates to providing access to seamless appropriate care, and insufficient provisions to address physician remuneration and lifestyle concerns results in a lack of accountability for comprehensive service provision to patients over continuums of time and geography. With such serious implications to health care budgets and public access to services, governments are struggling to eliminate these barriers.

The Current Situation: Policy Makers

One major lesson that has been learned from primary care projects in the past is that the all-or-nothing approach to the implementation of primary health care reforms has never been successful. There will always be physicians and patients who wish to maintain the

[12] – CFPC, 2001 Workforce Survey

status quo, and this has to be respected by policy makers. Smaller, incremental change looks more promising and this too has been slow in coming. In his journal article, "Primary Care In Canada: So Much Innovation, So Little Change" Brian Hutchinson outlines some possible reasons why this is the case[13].

First of all, the distribution of powers between federal and provincial governments on administration of health care has led to blame assignment and avoidance between the two, particularly throughout the economic downturn of the 1990s. This has slowed reform. Secondly, Medicare established a "founding bargain" between private physicians and government that instilled the concept of public payment for private practice into the collective consciousness of both physicians and governments. Third, the Canada Health Act of 1984 defined the criteria of "comprehensiveness of services" as those provided only in hospitals or by physicians. This reinforced the status quo of hospital and physician centered care, versus care by alternate providers in alternate settings. Last, but perhaps most influential of all, has been the cautious approach of politicians towards implementation of visionary measures. Primary health care renewal requires an up-front investment to reap the rewards of better utilization, and better impact on disease prevention and health promotion. However, political actors tend to limit their view to the four-year spans of time within which they operate. Constituents want immediate, tangible answers to their concerns and there is much pressure on politicians to comply in an immediate, tangible way[14].

Where do we go from here?

As previously stated, the key lesson learned from primary care renewal initiatives to date is that all-encompassing, across-the-board change is unlikely to succeed. Also, any attempt to strengthen and improve the quality of primary health care service delivery must have the support and participation of physicians[15].

Two other important lessons learned from the past are that there is a shortage of strong evidence in favour of any one model of organizing, funding and delivering primary care, and thus "discussions of innovations in primary care inevitably take place in an evidentiary vacuum". In lieu of strong evidence, history has shown that key stakeholders must be consulted in developing new policy initiatives, lest governments create policy that does not address real world concerns[16].

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[13] – Hutchinson, 127
[14] – Hutchinson, 119
[15] – Hutchinson, 123
[16] – Hutchinson, 124-125

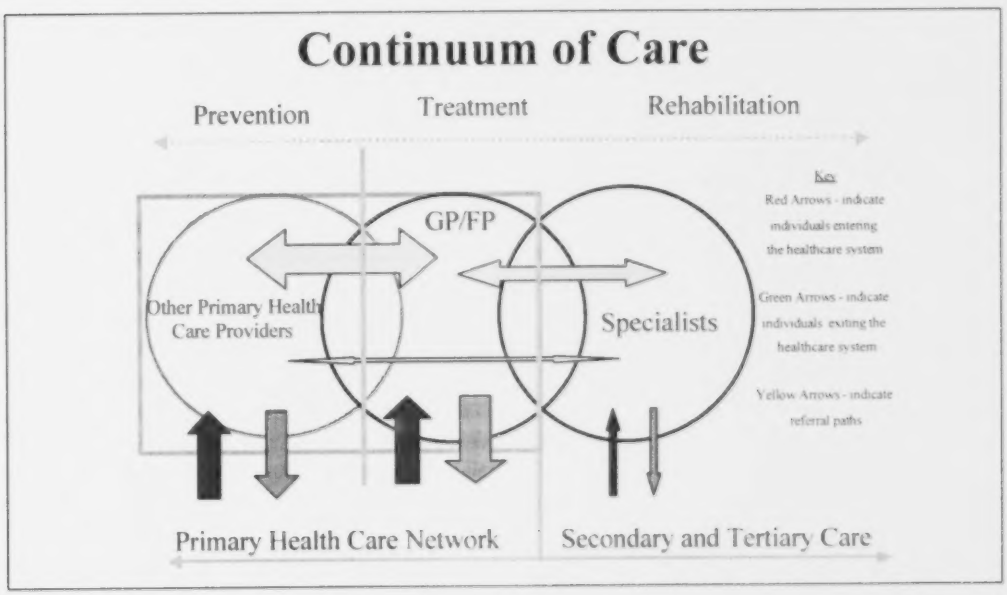
The Primary Care Advisory Committee: Stakeholder Input for Change

Vision

The PCAC envisages primary health care teams wherein primary care physicians work collaboratively with other health care providers and other physicians to provide a **Continuum of Care** (including preventative, promotive, curative, supportive and rehabilitative care) from small rural community settings to larger comprehensive health care institutions. Within each team, each health care provider practices at the highest level of his or her respective skill set. In this manner, all levels of primary health care are provided in an efficient manner with minimal redundancy. Primary health care teams are linked to hospitals and other health care institutions to minimize system disconnect and reduce resulting service gaps.

The individual patient/ client is at the centre of such a team with improved population health as the overarching goal. In concert with a supportive community, the primary health care team would encourage patient/client choice and self-reliance around decisions involving their health, with an emphasis on preventative health care and health promotion.

Individuals could receive seamless, timely, appropriate care from the most appropriate health care provider, who would be linked to other health care providers in the team should their expertise be required. The **Continuum of Care** illustrates how such a primary health care team would work in the context of comprehensive health care provision.



In this model, the FP/GP spans the spectrum between primary and secondary care. The expectation of the FP/GP is that he or she remains with a patient throughout their care upon entering the primary medical care system, drawing on the resources of the team to assist with patient care. In the same way, other health care providers in the primary health care team remain with their clients, collaborating with a physician or other health care provider when required. All health care providers in the primary health care team are encouraged to provide preventative, curative and rehabilitative care to individuals to the fullest extent of their skill set. While collaboration among health professionals is encouraged, existing relationships between patients and physicians as well as between clients and other health care providers have to be respected.

By maximizing the practice potential of other health care providers, family physicians would be liberated to work at the top of their respective skill set. This would provide a more challenging, flexible professional life for physicians and for all other health care providers. The ability to access professional development would address issues of clinical skills maintenance and upgrading for those FP/GPs who would like to focus on a particular specialty, or take on more complex cases. A reduced office workload, board privileges and a flexible payment method could encourage family physicians to work in hospitals. This would enable them to maintain their skills while providing valuable services to the community. The public would benefit from family physicians who are freer to pursue a role as patient advocate, who could consult with other FP/GPs, other health care providers and physician specialists on behalf of their patients at every level in the **Continuum of Care**.

Core Values

The PCAC recognizes that the FP/GP-patient relationship should not be undermined in any new framework for health services delivery, as it is historically, culturally and practically significant. Many individuals automatically look first to this relationship of trust for all of their health care needs. Currently, over 90% of medical services in Canada are provided by family physicians[17]. The family physician plays a unique role in the health care system in that he or she provides the link to other health care providers in the primary health care team and to specialists, thus the importance of the family physician-patient relationship should be stated. The PCAC realizes that immediate public and physician support of the proposed collaborative approach may be limited. Also, the value of the existing relationships between individuals and their primary health care providers is immeasurable and these relationships must be preserved within the context of collaborative practice. We feel that if our recommendations are progressively implemented, and individuals are well informed, a better understanding of the framework will ensue and new relationships of trust will be initiated between health care professionals and patient/clients.

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[17] – CFPC 2001 Workforce Survey

The PCAC recognizes that when individuals are sick, they should have a fundamental role in their own care. Informed choice is paramount. Individuals should have the right to choose their family physician and/or other health care provider, and this framework intends to preserve the patient/client's right to choose. With the patient/client at the core of primary health care delivery, it is a central belief of the committee that the interdisciplinary team follow a defined population of individual patient/clients over a continuum of time through a variety of health care settings on a twenty-four hour a day, seven day a week basis. This means that regardless of where and when an individual goes for a particular treatment, the primary health care team should have access to the individual's treatment record to enable comprehensive and streamlined care.

The Primary Care Advisory Committee developed the following guiding principles to reflect their core values and vision. Each recommendation has been filtered through these eleven principles to ensure that it is consistent with the values and goals of the committee.

Guiding Principles

1. The recommendations will promote the health and well being of the people of Newfoundland and Labrador
2. All recommendations will acknowledge the principles of the Canada Health Act
3. Recommendations will acknowledge that the health care system must be equitable and efficient, enabling choice for both patient and provider.
4. Recommendations will recognize the need for defined scopes of practice.
5. Recommendations will recognize the mutual responsibilities of professionals, individuals, and communities.
6. Recommendations will recognize the need for flexibility in the organization/structure of primary care networks and take into account the realities of different communities.
7. Recommendations will recognize flexibility in the compensatory mechanisms offered to physicians.
8. Recommendations will consider the change process required for implementation and the need for evaluation.
9. Recommendations will recognize the need for support of training and continuing education of health care professionals.
10. Recommendations will be realistic with regard to resource availability
11. Regarding primary health care, physicians will be part of primary health care networks.

Precepts

Accountability is a key theme of this committee, and any new model of primary health care delivery must be subject to an ongoing data collection and evaluation process. This is necessitated by the need to publicly demonstrate the validity of the new framework in this era of evidence-based medicine and increasingly informed public choice and higher expectations. High quality, applied research is necessary to fine tune related policy decisions in future to make sure that the highest quality of care is being provided to the public by the most efficient means.

Research has shown that small, incremental changes to primary health care delivery, as opposed to large scale, all-or-nothing changes, have been most successfully implemented in primary health care renewal. Reorganization cannot occur, however, until conditions permit the implementation of small changes. The PCAC recognizes that a critical mass of health care providers will be needed to implement primary health care teams across the province. In addition, a critical population mass will be necessary to support primary health care teams and professional competencies across the provinces. Regional differences in population number and demographics will cause the makeup of health care providers in each team to vary across the province. [18]

That being said, primary health care teams once established can only function effectively if there is strong support at provincial, regional and local levels for the interdisciplinary model of primary health care, unmediated by the conflicting demands of special interest groups. Stakeholder education, sound research and evaluation are critical to this process. In addition, there is an aura of mistrust among stakeholders in the health care system at present. This mistrust will require time, information, clear communication and opportunities for transparent stakeholder consultation to foster team building and acceptance of the interdisciplinary model.

Summary

In the context of primary care renewal, this committee believes that physicians, patients and governments must recognize their responsibilities towards one another to ensure that primary health care is delivered in the most efficient and effective way. The committee devised a diagram entitled the "Social Contract" to demonstrate the ways in which physicians, government and individuals are accountable to one another to ensure good population health. Balancing the interplay of expectations and accountabilities of physicians, the public, and government became a central theme of the committee, and our recommendations hopefully reflect this balance.

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[18] – Hutchinson, 127

We believe that the best possible recommendations are those based on the participation of not just one participant in this process in isolation, but of all stakeholders working in concert with one another. The recommendations listed below are grounded in our guiding principles, continuum of care model and social contract, which reflect this ideal. What unites physicians, other health care providers, government and the public in this process is that everyone wants a high-quality, accessible, fair, efficient and sustainable public health care system.

A prevailing theme of this committee is that we don't need to "tear the house down" in order to renew the health care system. The founding principles of Medicare are sound, there are plenty of best practices occurring throughout the province, and the foundation for a first-rate primary care system is already in place. All that is needed is the proper approach or "renovation" to make the positive elements of the system work harmoniously with one another. The future work of this committee will be to further develop the recommendations listed in this report into a blueprint for change.

RECOMMENDATIONS:

1. "It is recommended that government take the responsibility to set standards of access, communicate them to the public, and provide the funding to enable regional health authorities/ boards to identify and deliver a basket of services[19] to a defined population according to the health needs of that population"

Within the limitations of funding, government has to set standards for what the public has a right to expect within defined populations and geographical regions. Reasonable expectations should include the ability to access a **Continuum of Care** – from early preventative care to complex medical intervention – regardless of geographic location. In order to facilitate seamless health care provision for the public, policies need to be in place for service delivery. *A collective responsibility for health care should be fostered.* We envisage a rational framework of service delivery based on available data and stakeholder consultation. Evidence-based medicine is better for the public, and better for the sustainability of the health care system as a whole. It is important that decisions around standards of care for Newfoundlanders and Labradorians be immune to the influence of political interests.

Any new framework of health care delivery must be validated in order to translate it from paper to the real world. To validate the framework, ongoing evaluation is essential and the accountability must be transparent. Sufficient, valid and reliable data collection is necessary to ensure that provincial standards and accompanying practice decisions involved in care are being met, and to ensure the integrity of the framework. Physicians should be involved in community-based research to collect data on patient populations. Evaluation of these data should drive future policy and guide the evolution of the proposed model. The public's access and public health outcomes must be demonstrated to improve with the introduction of any new framework. Regional health authorities need to have a means to collect appropriate data, and a monitoring system needs to be in place whereby information can be transmitted to government and the public so evaluation of data can occur.

Primary health care delivery principles such as a team approach to care with networks of health care providers working in collaboration with one another and with collective responsibility towards patients linked with a population approach to healthcare have been around since the 1970's. Despite persistent calls for change from special interest groups, physician groups, social policy research organizations, and independent committees such as this one, changes have only occurred on a small scale. This can be attributed to the barriers to change outlined in the preamble. To remove some of these barriers, the following framework for primary care delivery has been suggested in addition to the overarching recommendation above.

[19] – see Appendix E – Basket of Services for Primary Health Care Teams

2. **"It is recommended that integrated primary health care services be provided in a defined geographical location. Integration could be accomplished through the use of single sites, clustering, virtual networks, or other means."**

Working in linked service clusters gives physicians the opportunity to consult with other physicians and health care providers on a regular basis, thus enhancing the care they provide to individuals. This can also serve to reduce isolation and burnout. Collaborating with other health care providers in a primary health care team is an asset to physicians as it can free up their time to practice medicine in the manner that they have been trained. Within the proposed framework, a range of services would be provided to specific geographic regions and/or demographic populations. Public access could be improved by service clustering.

3. **"It is recommended that the system provide the opportunity for all team members to function collaboratively within their full scope of practice, in order to provide them with an enriching professional life and enable the best use of health human resources."**

The challenge of the framework is to have all health care providers working at the highest level of their respective skill sets, and linked in such a way to accommodate the various needs of the patient/client. This will result in little redundancy in the services provided and health care providers will be able to have challenging, rewarding practices. Providers need to be informed on the scopes of practice of other health care providers to facilitate this transition. Orientation and professional development for existing interdisciplinary providers will be required to enable all health care providers to understand each other's professional competencies. Individual patient/client needs should be addressed by the most appropriate health care professional(s). Patients/clients will be able to manage their health concerns with the most appropriate supports.

4. "It is recommended that whoever is the first point of contact for the patient/client will make the clinical decision, within their scope of practice.

Otherwise, collaboration with other health care providers[20] in the team should determine management and therapeutic options"

We recognize that in excess of 90% of primary medical care is currently provided by physicians[21]. However, in the collaborative care model, when an alternate health care provider is the first point of contact, they will make the clinical decision within their scope of practice.

To facilitate the provision of a broader range of services, existing physician-patient relationships must be respected. Patients must have the choice to participate, or not to participate, in the framework. Under the new framework, individuals will have the ability to seek primary health care from a variety of providers within the team. However, physicians have traditionally been the first point of contact for individuals with medical care needs, and the clinical leaders of care under these circumstances. Any concerns physicians may have about liability in the provider team should be mitigated by legislation around provider scopes of practice.

5. "It is recommended that enhanced patient/client education be provided to enable self-care"

Patient/client education is essential to enable self-care. We recognize that people approach their own health care with different levels of knowledge, skill and understanding. More than ever, individuals seek to be informed about health care options. A goal of primary health care is to empower individuals to the best of their ability to take control of their own health. However, this will not happen through educative measures alone. Other health indicators such as social support, employment, income and social status will influence the effectiveness of education on encouraging self-care. Education will have the greatest benefit for individuals who live in an environment that promotes self-reliance. For example, those who are literate and economically self sufficient, who have a supportive home environment and a community that promotes independent living, will profit the most from educational campaigns. We should promote self-reliance, and the individual having a locus of control around their own care, with an appreciation of all of the factors involved in reaching this goal. Within this framework, the focus of all health care providers must be on the patient/client as the "hub" of the primary health care team.

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[20] see Appendix F – Suggested list of Other Health Care Providers

[21] CFPC 2001 Workforce Survey

Co-ordination of Primary Medical Care and Leadership

6. "It is recommended that under this framework, every participating physician in a physician network have a defined relationship with a governance structure such as a regional health authority or board."

"Such a relationship shall involve an agreement that includes, but is not limited to, the following:

(a) A service commitment for a defined basket of medical services[22] to be delivered to a defined population. The physicians and the boards will agree on what medical services are to be provided and by which individual physician. The physician group will ensure delivery of the medical services.
(b) The level of remuneration for such services will be determined by provincial policy. The method of remuneration will be determined at the local level as set out in the agreement.
(c) The method and details of monitoring for evidence based decision making
(d) The method and details of an ongoing evaluation process

The mandate of regional boards is to know the health needs of the populations they serve. Boards could outline for physicians what medical services are required for their region. Physician groups could enter into formal arrangements with boards such that each physician in the network could decide what medical services he or she wishes to provide to the community, provided that the group ensure delivery of the full basket of services listed in the agreement.

In order to support physician affiliation with boards, the physician-board privilege needs to be highlighted. Physicians are trained to, and expect to, provide hospital services such as emergency room coverage and obstetrics after graduation. However, the current model of service provision offers little encouragement for them to continue to do so. With practices filled to capacity, little time or incentive exists for physicians to take on these sorts of hospital and community-based services and still have a reasonable lifestyle.

Board affiliation would provide physicians with the privileges and opportunities for networking, continuing medical education and professional development. Board affiliation should have provisions in place for physicians who wish to withdraw. Government will need to support joint physician-board decision making and ensure that an appropriate complement of health care professionals are available to support the balance across primary health care services. Finally, expectations of workload would

[22] – See Appendix G for Basket of Services for FP/GP

need to be reasonable. These expectations should factor in current physician practice and lifestyle concerns.

7. **"It is recommended that the composition of the physician network ensure that comprehensive medical care is provided. Government should enable GPs to acquire enhanced skills to deliver a broad range of services within a defined population, by ensuring: appropriate remuneration, funding while training, and linkages to community needs"**

Under our current system of health service delivery, gaps exist between public expectations and physician provision of primary care services. In some cases this may be due to increasing or inappropriate demands for service. However, this may also be attributed a shift in the balance between the individual physician choice of practice and their attempt to address their lifestyle concerns.

This recommendation would accommodate the diversity of practice interests found among physicians as well as changing services provided by an individual physician over his or her life span. For example, if one physician in the network wished to focus his or her practice on emergency medicine and another on obstetrics, the board-physician group affiliation would encourage these physicians to pursue their respective interests in order to provide the complete basket of services. The medical school has an obligation to custom design their training to reflect community needs. In this manner, the public's primary care needs could be met without compromising (in fact - by enhancing) physician choice of practice.

A critical mass of physicians and appropriate remuneration for specified services are needed to support these changes. Professional development will enable all team members to practice at the top level of their skill set. Professional development needs to be provided, supported and remunerated. Without the opportunity to change the intensity and shift the focus of their practices, physician burnout becomes a very real possibility.

Funding & Remuneration

8. **"It is recommended that any funding mechanism proposed must have standards of payment that can be applied provincially"**

Provincial standards for physician remuneration must exist to eliminate interregional competition, while maintaining recognition of geographic isolation and allowing flexibility for the boards to fund programs in innovative ways.

9. **"It is recommended that any proposed funding mechanism should not negatively impact on physician incomes for comparable levels of service"**

Without question, physicians should be permitted to decide whether or not they wish to participate in any funding model proposed under the new framework. There should be an opt-out clause for physicians to exit the proposed model should they so choose. Provisions for office overhead as well as salaries for other health care providers and administrative staff will need to be considered in any new funding model.

10. **"It is recommended that any funding mechanism should encourage reasonable access to physician services throughout the province. Funding mechanisms for physicians should facilitate access by including appropriate remuneration for on-call, after hours care, committee work, etc."**

Government will need to research funding mechanisms and find the right elements to suit the unique demographic and geographic challenges to physician practice in Newfoundland and Labrador. Currently, both fee-for-service and salaried remuneration mechanisms are in place in the province. Neither system singularly supports performing on-call services or meeting professional obligations.

11. **"It is recommended that the funding mechanism should be flexible, and could be blended. The funding mechanism should promote and facilitate the interdisciplinary approach to care"**

The committee has agreed that there is no perfect funding mechanism for physician services in the renewed primary care delivery framework. There exists considerable literature expounding the merits and pitfalls of the different payment models. There is, however, very little credible scientific evidence that supports any single payment model as advantageous over another. An option is a blended funding mechanism, one that combines a series of remuneration methods. Blended funding arrangements may include, but may not be limited to, fee-for-service, fee-for-time (sessional) and salaried remuneration methods. The most recent trend across Canada supported by the Canadian College of Family Practice (CCFP) is a blended model that incorporates a base salary and limited fee-for-service payments.

The committee neither endorses nor discredits this model of payment. The real issue of implementing new work structures and health care provider relationships, however, suggests that alterations to existing funding models in the province would address barriers to change. The committee cautions that whatever the nature of the payment model, it should complement the principles and the recommendations contained in this report and should enhance the collaborative nature of a primary health care team.

Framework Implementation & Change Management

In order to engage physicians and other health care providers in this model, several key points must be addressed to implement the framework. Coordination and leadership at provincial, regional and local levels will be necessary to make a smooth transition to the framework. To facilitate effective communication among health care providers, there must be an integration of patient information, preferably through the electronic health record (E.H.R.). Bridge funding will have to be provided for physicians and other providers to develop the network. As well, coordinating personnel will need to be hired to develop and support the network in collaboration with the primary care team. Changes will need to be made to existing funding models to support integrated service delivery. Education on scopes of practice of other providers will be necessary to facilitate appropriate referral procedures. Finally, coordination and leadership at provincial, regional and local levels will be necessary to determine a framework to develop and sustain the network. The committee further recommends that the following initiatives involving communication and education be put into place once the primary care delivery framework has been accepted.

Building Trust

12. "It is recommended that government inform all stakeholders regarding the underlying purpose of, as well as the priorities and procedures involved in the new framework"

There is a need to build trust among all stakeholders in the health care system when implementing any changes to their working relationships and practice environments. Currently, this committee feels that based on its discussions, trust levels among physicians, other health care providers and health care administrators is generally low. For changes to occur, positive, supportive and respectful working environments that already exist must not be detrimentally affected by change implementation. Where such environments do not exist, trust must be fostered before any changes can be made.

This committee strongly recommends that in order to facilitate buy-in of all health care professionals and cultivate an acceptable climate for change, an evolutionary process of change should be stressed. Information and opportunities for consultation should be readily available to stakeholders as changes are incrementally implemented.

Education

13. "It is recommended that existing professional schools and training programs should promote the interdisciplinary model. Opportunities for students to become familiar with the model throughout their training are required."

To best create a climate for change in the future, we must look to our students entering health care professions as the starting point. Current training programs are designed to meet the needs of the current health care system. When changes are implemented to that system, students should logically be trained in a manner that reflects the needs of the communities they intend to serve and the structure of the system they intend to enter.

Leadership and Coordination

14. "It is recommended that the FP/GP remain as the primary referral agent to a medical specialist. A process should be developed for (yet-to-be) defined exceptions to the referral process through changes to existing legislation"

Every health care provider is expected to practice at the highest level of his or her skill set. Whenever problems arise that require a higher skill set, the patient should be referred to the health care provider with the appropriate level of skill. In this way, appropriate referrals are made which contribute to efficiency and timely care. The FP/GP should, with defined exceptions, continue to be the referring agent to physician specialists. This permits the FP/GP to directly manage patients within their skill set, such that appropriate referrals continue to be made to physician specialists. This method of referral ensures that the patient/client receive the optimal care with appropriate utilization of health care provider resources.

Conclusion

The Primary Care Advisory Committee feels that the above recommendations represent a solid foundation for primary care renewal. We have accomplished much, but there is still much to be done. Further evaluation of existing research on the issues is necessary to devise an implementation strategy for each of the above recommendations. A thorough evaluation of stakeholder concerns as expressed through the Provincial Health Forums will be required to formulate this strategy. We must move from answering the question "What needs to be done?" to asking the question "How shall we do it?" It is suggested that a future role of the PCAC would be to support and coordinate implementation strategies for the recommendation contained in this framework, as per the ninth term of reference for the Primary Care Advisory Committee.

APPENDIX A

Primary Care Advisory Committee Membership

Committee Chair:	Kathy LeGrow	St. John's
Ex-Officio(DOHCS)	Ed Hunt	St. John's
Medical Directors		
Urban	Bob Williams	St. John's
Rural	Michael Jong	Goose Bay
GP and Other Members:		
Clarenville Project	Blaine Pearce*	Clarenville
Primary Health Care Enhancement Project	Mohamed Ravalia	Twillingate
Nurse	Karen Noel Appointed by the ARNNL	Clarenville
Rural/Recent Graduate	Jody Woolfrey	Botwood
Urban/Senior Physician	Patrick O'Shea*	St. John's
Clinical Skill Assessment & Training	Francine LeMire	Corner Brook
Nurse Practitioner	Bev McIsaac Appointed by the CNS	St. John's
Public Health	Minnie Wasmeier	Corner Brook
Public Policy	Jim Feehan	St. John's
Consumer	Marie White**	St. John's
Physician Association	Sue King* Appointed by the NLMA	St. John's
MUN Medical School	Ian Bowmer	St. John's

* - Non-participating physicians as of mid-October 2001

** - Resigned October 29, 2001

APPENDIX B

Primary Care Advisory Committee
Working Group Members

Consumer Representatives:

	Mr. Chris Rusted	St. John's
	Mr. Walter Vincent	Corner Brook

Other Representatives:

Physiotherapist	Lorie Paterson	Bonavista
CEO, Institutional Health Care Board	George Butt	Carbonear
Barrister/Solicitor	Vern French	St. John's
Nurse Practitioner/ Educator (CNS)	Madge Applin	St. John's
Medical School/DOHCS/ Rural Physician	Con O'Maonaigh	St. John's
Pharmacist	Donald F. Rowe*	St. John's
DOHCS/ Urban Physician	Blair Fleming	St. John's
Treasury Board	Paula Fagan	St. John's

Steering Committee/Technical Support

Sheila Tucker, Policy & Planning Branch, DOHCS
Mike Doyle, Medical Services Branch, DOHCS
Jodi Oliver, Medical Services Branch, DOHCS
John Downtown, Pharmaceutical Services Branch, DOHCS
Dr. Con O'Maonaigh, MUN Medical School (consultant to DOHCS)
Dr. Ed Hunt, Medical Services Branch, DOHCS
Kathy LeGrow, PCAC Chair

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* - Declined Appointment

APPENDIX C

Primary Care Advisory Committee Working Groups

Compensation Working Group

Francine LeMire, Chair
Patrick O'Shea*
Jim Feehan
Mohamed Ravalia
Jody Woolfrey
Blair Fleming
Con O'Maonaigh
Mike Doyle (tech support)

Contracts Working Group

Ian Bowmer, Chair
Bob Williams
Bev McIsaac
Ed Hunt
Paula Fagan
George Butt
Vern French
Sue King*
Jodi Oliver (tech support)

Service Expectations Working Group

Marie White, Chair**
Michael Jong
Karen Noel
Minnie Wasmeier
Walter Vincent
Chris Rusted
Blaine Pearce
Madge Applin
Lorie Paterson
Sheila Tucker (tech support)

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* - non-participating as of mid-October 2001

** - resigned, October 29, 2001

APPENDIX D

Presentations to the PCAC

September 7th, 2001	
Mike Doyle Economist DOHCS	Principles of Medicare: Equity/Efficiency Funding Models
Sheila Tucker DOHCS	National Framework
Dr. Brendan Barrett Epidemiology Unit MUN	Primary Care Research
Dr. Cathi Bradbury Director, Medical Services DOHCS	Service Delivery Issues
Dr. Karl Misik President NLMA	Professional Issues
Bryson Webb Chair, Primary Health Care Enhancement Project Committee	Consumer Issues
September 27th, 2001	
Dr. Paul Bonisteel President, Newfoundland Chapter College of Family Physicians of Canada (CFPC)	Primary Care in Canada: A Prescription for Renewal
October 17th, 2001	
Mr. Mike Barron Ms. Margo Priddle Newfoundland & Labrador Center for Health Information	Electronic Health Records
Mr. Robert Thompson Deputy Minister DOHCS	Departmental Issues

APPENDIX E

Basket of Services for Primary Health Care Teams[1]

1. Focus on Health Promotion
2. Focus on disease prevention, including screening
3. Chronic disease follow-up
4. Mental health and Addictions counselling
5. Acute care services (within FP/GP scope of practice) including inpatient hospital services
6. After hours services (e.g. Group call, after hour clinics, home visits)
7. Emergency services
8. Long term care and palliative care support
9. Attendance at multidisciplinary and planning committees
10. Interdisciplinary teaching activities
11. Professional development to ensure up-to-date knowledge and skill
12. Physician involvement in advocacy at the individual, community and provincial level
13. Training in information technology and information management for the single patient file or electronic health record
14. Obstetrics/Delivery performed by GP/FP
15. Collaboration among team members, with families and communities
16. Report writing, charting and other communication
17. Research and ongoing performance assessment

[1] – as suggested by the PCAC Service Expectations Working Group, September 27, 2001

APPENDIX F

Suggested list of Other Health Care Providers[1]

1. Nurse
2. Nurse Practitioner
3. Social Worker
4. Occupational Therapist
5. Physiotherapist
6. Psychologist
7. Dietician
8. Pharmacist
9. Pastoral Care Worker
10. Speech-Language Pathologist
11. Audiologist
12. Health Educator
13. Midwife
14. Mental Health Worker
15. Home Support Worker
16. Addictions Counsellor
17. Family Members
18. Community Health Nurse[2]
19. Licensed Practical Nurse[2]
20. Nutritionist[2]
21. Dentist[2]
22. Dental Hygenist[2]

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[1] – Not intended to be an exhaustive list for our purpose. Adapted from the Working Group on Interdisciplinary Primary Care Models, Advisory Committee of Interprofessional Practitioners (AGIP). Interdisciplinary Primary Care Models: Final Report *Appendix 2 – 24 Regulated Health Professionals in Ontario*. April, 1997.

[2] – Some suggested additions from PCAC members

APPENDIX G

Basket of Services for GP/FP[1]

1. Health Assessment
2. Clinical evidence-based illness prevention and health promotion
3. Appropriate interventions for episodic illness and injury
4. Primary Reproductive Care
5. Early Detection, Initial and Ongoing Treatment of Chronic Illnesses
6. Care for the majority of illnesses (in conjunction with specialists as needed)
7. Education and Support for self-care
8. Support for In-Home Long Term Care Facility and Hospital Care
9. Arrangements for 24-hour/7-day a week response
10. Service Coordination and Referral
11. Maintenance of a comprehensive client health record for each rostered consumer in the primary health care agency
12. Advocacy
13. Primary Mental Health Care including Psycho-Social Counseling
14. Coordination and Access to Rehabilitation
15. Support for people with a terminal illness

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[1] - adapted from the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCAR), 1996 "Common Set of Mandatory Functions", as referenced in the CFPC document Primary Care and Family Medicine in Canada: A Prescription for Renewal" Appendix 2, October 2000

The Family Physician's Role in a Continuum of Care Framework for Newfoundland and Labrador

Report of the Primary Care Advisory Committee
Kathy LeGrow, Chair

EXECUTIVE SUMMARY

In June 2001, medical directors and physicians from the each of the regional health boards in Newfoundland and Labrador called a meeting with the Department of Health and Community Services to voice their concerns the current crisis in primary care delivery, about including issues around recruitment and retention of physicians, and service gaps in hospitals. In response, Minister Julie Bettney appointed a committee to address their concerns. The **Primary Care Advisory Committee (PCAC)** first met on September 7th, 2001. The mandate of the PCAC was to advise the Department of Health and Community Services (DOHCS) on physician issues related to primary care renewal and to make recommendations to the Minister of Health and Community Services on a framework for primary care which facilitates the effective and timely implementation of primary health care renewal in Newfoundland and Labrador.

Process

The PCAC has met six times since its inception, working towards consensus on the issues surrounding primary care and the recommendations to address these issues. Full consensus was achieved, and by the committee's definition, this means that each member can "live with" the issues and recommendations that are presented in this report. The recommendations in this report define the family physician's role in a **Continuum of Care** framework.

Parameters

The World Health Organization defines Primary Health Care as "the first level of contact of individuals, the family and the community with the national health care system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process".

Primary care is defined as the first level of contact with medical care, that which is provided by a physician, be it via an emergency room visit, office appointment or house call. The terms "primary medical care" and "primary care" are interchangeable in the health care field. Primary health care is the larger context inside which primary medical care operates.

A major theme that has emerged through earlier pilot projects in primary health care renewal is t hat physician endorsement is vital to the success of primary care reform. This committee focused on achieving physician endorsement of primary care renewal initiatives in the broader context of primary health care.

Findings

Physicians are generally not encouraged to participate in primary health care renewal initiatives due to systemic barriers to change. These barriers to change are exacerbated by a national physician shortage that particularly impacts Newfoundland.

The committee identified three main barriers to change in the current system:

- **Payment Models**

Deficiencies in the current fee-for-service arrangements and payment schedules may hamper primary health care renewal, particularly the interdisciplinary approach to service delivery. An important shortcoming of the present fee-for-service system is the absence of compensation for continuing medical education and professional development. One exclusive compensation system does not sufficiently allow the health care delivery system to adapt to the changing needs of the population.

- **Physician Lifestyle**

Physician shortages result in increased workload for physicians. Both salaried and fee for service physicians are challenged to find a balance between providing optimal patient care and having a reasonable lifestyle.

- **System disconnection**

The current service delivery structure does not foster coordinated approach to care. In particular, there is inadequate integration between family physicians and secondary/tertiary facilities. This is partly due to geographic constraints and chronic physician shortages. The lack of interdisciplinary contact to date, may be both the cause and the effect, of an absence of trust and confidence among various health professionals.

Policy Implications

The committee feels government should set and support standards of access to a **Continuum of Care** for all residents of the province. Within this continuum would be a basket of primary health care services to be provided to each region by its health authorities or board(s) based on the health needs of the population they serve. The health needs of the population should be determined by sound research evidence and/or stakeholder input where good data does not exist. These services should be provided by integrated primary health care teams, linked either by geographic, virtual or other means. To minimize redundancy of services, team members should function collaboratively within their scopes of practice, at the highest level of their skill set. This would also ensure that patients/clients would be able to manage their health concerns with the most appropriate supports.

Where relationships between individuals and physicians or other health care providers already exist, these should be respected and every individual should have the option to participate or not participate in the primary health care team approach. Patient/client informed choice is paramount in the proposed primary care delivery framework. Patient/client education is required to enable enhanced self-care, recognizing the complex interrelationship of factors that contribute to self-reliance around personal health care choices.

Within the proposed framework for primary care, the committee feels that family physicians should form relationships with regional governance structures (ie. Health boards). In this way, groups of physicians could provide the necessary medical services suggested in the basket of services provided by the board based on access standards for their population. In return, boards could provide the privileges associated with affiliation, including access to continuing medical education and collegiality. The physician parties and the board should sign an agreement determining the services to be provided and the remuneration, as well as monitoring and evaluation, standards. Government should provide access to enhanced training for physicians who wish to link their practices to community needs. In this way, service gaps could be minimized and family physicians could continue to advocate for their patients throughout the continuum of care.

It was agreed that any new funding model for physicians should have standards that could be applied provincially. Also, it should not negatively impact the goals of the proposed framework, nor physician incomes or patient outcomes. The funding model should be flexible enough to accommodate regional diversity and could perhaps incorporate features of existing funding models in a blended way.

For all of the above policy changes to occur, the committee recognizes that evolutionary implementation and access to information on the framework will be necessary to build trust among stakeholders. As well, training will be necessary for all health care providers at the student level and beyond to become familiar with the interdisciplinary approach to care suggested in the framework. Finally, as the GP/FP provides the link between primary health care and secondary health care in the **Continuum of Care**, it was recognized that existing referral patterns (from the GP/FP to the physician specialist) should be maintained, with consideration of exceptions as yet to be defined.

This report is not intended to instruct policy makers on how to implement primary care renewal, rather it should serve as a foundation for future policy decisions. The PCAC believes that policy decisions surrounding implementation of these recommendations would be best informed by further committee discussions utilizing the transparent process developed for this purpose.